TRADITIONAL COPAYMENT PLANS – FEATURES AT A GLANCE

This is a summary of the most frequently asked-about benefits and their copayments and coinsurance. For information on benefits, copayments, and coinsurance, please refer to the *Disclosure Form* enclosed with this booklet. Detailed information about your plan is included in the *Membership Agreement*, which will be mailed to you upon acceptance.

FEATURES	PLATINUM Rx	PLATINUM
Annual individual deductible (per calendar year)	None	None
Annual out-of-pocket maximum (per calendar year)	$2,000 member $6,000 family	$2,500 member $7,500 family
Lifetime benefit maximum	None	None
PROFESSIONAL SERVICES		
Office visits[1]	$20 per primary care visit	$25 per primary care visit
For diagnosis and treatment by primary care providers, consultation and treatment by specialists, routine physical and hearing exams, well-baby visits through age 2, prenatal care, eye exams, and urgent care	$30 per specialty care visit	$35 per specialty care visit
OUTPATIENT SERVICES		
Laboratory		
Inpatient Outpatient	Included under hospital care $15 per visit	Included under hospital care $15 per visit
X-rays and other special procedures		
Inpatient Outpatient	Included under hospital care $25 per visit	Included under hospital care $25 per visit
Outpatient Rx drugs		
When prescribed by a Kaiser Permanente physician or a licensed dentist in accordance with our formulary process	Full charge for Rx costing $15 or less; the greater of $15 or 50% of charges for Rx costing $15 or more[2]	Not covered
HOSPITALIZATION SERVICES		
Hospital care (including maternity care)		
All inpatient care is covered after payment of applicable copayments. There are no limits on prescribed hospital days.	$300 per day, up to $1,500 per admission	$500 per day, up to $2,500 per admission
EMERGENCY HEALTH COVERAGE		
Emergency care[1]		
Within and outside Kaiser Permanente service area	$100 copay[3]	$100 copay[3]

For specific plan information, see the following forms: for Platinum Rx, *W-O-ID-PLAT-RX-1007*; Platinum, *W-O-ID-PLAT-1007*; Gold $500 Plan, *W-O-ID-G500-1007*; for Gold $1,000 Plan, *W-O-ID-G1000-1007*; for Silver $1,500, *W-O-ID-S1500-1007*; for Silver $2,500 Plan, *W-O-ID-S2500-1007*; for Silver Plus $3,500 Plan, *W-O-ID-SP3500-1007*; for Silver $3,500 Plan, *W-O-ID-S3500-1007*; for $1,500 Deductible Plan with HSA Option, *W-O-ID-H1500-1007*; for $1,500 Deductible/Rx Plan with HSA Option, *W-O-ID-H1500-RX-1007*; for $2,600 Deductible Plan with HSA Option, *W-O-ID-H2600-1007*; for $2,600 Deductible/Rx Plan with HSA Option, *W-O-ID-H2600-RX-1007*. The appropriate form will be mailed to you after approval.

In accordance with Oregon law, your plan selection may be limited based on the results of your health questionnaire.

[1]Plus any copayments for lab or X-ray

[2]Mail order: 30-day supply per cost share above

[3]The emergency care copay will be waived and the hospital copay will apply if admitted directly to the hospital from an Emergency Department. Additional copayments or coinsurance may apply for lab, X-ray, etc.

DEDUCTIBLE PLANS – FEATURES AT A GLANCE

This is a summary of the most frequently asked-about benefits and their copayments and coinsurance. For information on benefits, copayments, and coinsurance, please refer to the *Disclosure Form* enclosed with this booklet. Detailed information about your plan is included in the *Membership Agreement*, which will be mailed to you upon acceptance.

FEATURES	GOLD $500	GOLD $1,000
Annual individual deductible (per calendar year)	$500 individual $1,500 family	$1,000 individual $3,000 family
Annual out-of-pocket maximum (per calendar year)	$3,750 member $11,250 family	$2,500 member $7,500 family
Lifetime benefit maximum	$2 million	$2 million
PROFESSIONAL SERVICES		
Office visits[1]	$25 per primary care visit (deductible waived)	$25 per primary care visit[2]
For diagnosis and treatment by primary care providers, consultation and treatment by specialists, routine physical and hearing exams, well-baby visits through age 2, prenatal care, eye exams, and urgent care	$35 per specialty care visit[2]	$35 per specialty care visit[2]
OUTPATIENT SERVICES		
Laboratory		
Inpatient Outpatient	Included under hospital care $15 per visit[3]	Included under hospital care $15 per visit[3]
X-rays and other special procedures		
Inpatient Outpatient	Included under hospital care $25 per visit[3]	Included under hospital care $25 per visit[3]
Outpatient Rx drugs		
When prescribed by a Kaiser Permanente physician or a licensed dentist in accordance with our formulary process	Optional: Rx deductible: $500[4] Retail: 50% (after deductible) up to $150 maximum per 30-day Rx[5]	Optional: Rx deductible: $500[4] Retail: 50% (after deductible) up to $150 maximum per 30-day Rx[5]
HOSPITALIZATION SERVICES		
Hospital care (including maternity care)		
All inpatient care is covered after payment of applicable copayments. There are no limits on prescribed hospital days.	$750 per day up to $3,750 per admission (after deductible)	$500 per day up to $2,500 per admission (after deductible)
EMERGENCY HEALTH COVERAGE		
Emergency care[1]		
Within and outside Kaiser Permanente service area	$100 copay (after deductible)[6]	$100 copay (after deductible)[6]

In accordance with Oregon law, your plan selection may be limited based on the results of your health questionnaire.
[1]Plus any copayments for lab or X-ray
[2]After deductible; deductible waived for well-baby visits, prenatal care, and certain preventive procedures
[3]After deductible; no deductible for most preventive tests or preventive procedures
[4]Rx deductible is per calendar year and does not count toward medical deductible.
[5]Mail order: up to 90-day supply for maintenance drugs; will not exceed two times the copay max (i.e., $300)
[6]The emergency care copay will be waived and the hospital copay will apply if admitted directly to the hospital from an Emergency Department. Additional copayments or coinsurance may apply for lab, X-ray, etc.

DEDUCTIBLE PLANS – FEATURES AT A GLANCE

SILVER $1,500	SILVER $2,500	SILVER PLUS $3,500	SILVER $3,500
$1,500 individual $4,500 family	$2,500 individual $7,500 family	$3,500 individual $10,500 family	$3,500 individual $10,500 family
$5,000 member $15,000 family	$7,000 member $21,000 family	$9,000 member $27,000 family	$9,000 member $27,000 family
$2 million	$2 million	$2 million	$2 million
PROFESSIONAL SERVICES			
$25 per primary care visit[2]	$25 per primary care visit[2]	$25 per primary care visit (deductible waived)	$25 per primary care visit[2]
20% coinsurance per specialty care visit[2]	30% coinsurance per specialty care visit[2]	30% coinsurance per specialty care visit[2]	30% coinsurance per specialty care visit[2]
OUTPATIENT SERVICES			
Included under hospital care 20% coinsurance[3]	Included under hospital care 30% coinsurance[3]	Included under hospital care 30% coinsurance[3]	Included under hospital care 30% coinsurance[3]
Included under hospital care 20% coinsurance[3]	Included under hospital care 30% coinsurance[3]	Included under hospital care 30% coinsurance[3]	Included under hospital care 30% coinsurance[3]
Optional: Rx deductible: $500[4] Retail: 50% (after deductible) up to $150 maximum per 30-day Rx[5]	Optional: Rx deductible: $500[4] Retail: 50% (after deductible) up to $150 maximum per 30-day Rx[5]	Optional: Rx deductible: $500[4] Retail: 50% (after deductible) up to $150 maximum per 30-day Rx[5]	Optional: Rx deductible: $500[4] Retail: 50% (after deductible) up to $150 maximum per 30-day Rx[5]
HOSPITALIZATION SERVICES			
20% coinsurance (after deductible)	30% coinsurance (after deductible)	30% coinsurance (after deductible)	30% coinsurance (after deductible)
EMERGENCY HEALTH COVERAGE			
20% coinsurance (after deductible)	30% coinsurance (after deductible)	30% coinsurance (after deductible)	30% coinsurance (after deductible)

For specific plan information, see the following forms: for Platinum Rx, *W-O-ID-PLAT-RX-1007*; Platinum, *W-O-ID-PLAT-1007*; Gold $500 Plan, *W-O-ID-G500-1007*; for Gold $1,000 Plan, *W-O-ID-G1000-1007*; for Silver $1,500, *W-O-ID-S1500-1007*; for Silver $2,500 Plan, *W-O-ID-S2500-1007*; for Silver Plus $3,500 Plan, *W-O-ID-SP3500-1007*; for Silver $3,500 Plan, *W-O-ID-S3500-1007*; for $1,500 Deductible Plan with HSA Option, *W-O-ID-H1500-1007*; for $1,500 Deductible/Rx Plan with HSA Option, *W-O-ID-H1500-RX-1007*; for $2,600 Deductible Plan with HSA Option, *W-O-ID-H2600-1007*; for $2,600 Deductible/Rx Plan with HSA Option, *W-O-ID-H2600-RX-1007*. The appropriate form will be mailed to you after approval.

HSA-QUALIFIED PLANS – FEATURES AT A GLANCE

This is a summary of the most frequently asked-about benefits and their copayments and coinsurance. For information on benefits, copayments, and coinsurance, please refer to the *Disclosure Form* enclosed with this booklet. Detailed information about your plan is included in the *Membership Agreement*, which will be mailed to you upon acceptance.

FEATURES	$1,500 DEDUCTIBLE/Rx	$1,500 DEDUCTIBLE
Annual individual deductible (per calendar year)	$1,500 individual $3,000 family	$1,500 individual $3,000 family
Annual out-of-pocket maximum (per calendar year)	$5,000 member $10,000 family	$5,000 member $10,000 family
Lifetime benefit maximum	$2 million	$2 million
PROFESSIONAL SERVICES		
Office visits[1]	20% coinsurance per per primary care visit[2]	20% coinsurance per per primary care visit[2]
For diagnosis and treatment by primary care providers, consultation and treatment by specialists, routine physical and hearing exams, well-baby prenatal care, eye exams, and urgent care	20% coinsurance per specialty care visit[2]	20% coinsurance per specialty care visit[2]
OUTPATIENT SERVICES		
Laboratory		
Inpatient Outpatient	Included under hospital care 20% coinsurance[3]	Included under hospital care 20% coinsurance[3]
X-rays and other special procedures		
Inpatient Outpatient	Included under hospital care 20% coinsurance[3]	Included under hospital care 20% coinsurance[3]
Outpatient Rx drugs		
When prescribed by a Kaiser Permanente physician or a licensed dentist in accordance with our formulary process	$15 generic prescription $30 brand-name prescription (30-day supply, after deductible)[4]	Not covered
HOSPITALIZATION SERVICES		
Hospital care (including maternity care)		
All inpatient care is covered after payment of applicable copayments. There are no limits on prescribed hospital days.	20% coinsurance (after deductible)	20% coinsurance (after deductible)
EMERGENCY HEALTH COVERAGE		
Emergency care[1]		
Within and outside Kaiser Permanente service area	20% coinsurance (after deductible)	20% coinsurance (after deductible)

For specific plan information, see the following forms: For $1,500 Deductible Plan with HSA Option, *W-O-ID-H1500-1007*; for $1,500 Deductible/Rx Plan with HSA Option, *W-O-ID-H1500-RX-1007*; for $2,600 Deductible Plan with HSA Option, *W-O-ID-H2600-1007*; for $2,600 Deductible/Rx Plan with HSA Option, *W-O-ID-H2600-RX-1007*. The appropriate form will be mailed to you after approval.

[1]Plus any copayments for lab or X-ray
[2]After deductible; deductible waived for well-baby visits, prenatal care, and certain preventive procedures
[3]After deductible; no deductible for most preventive tests or preventive procedures.
[4]Mail order: two copays for up to a 90-day supply of maintenance drugs